Michigan Department of Community Health Division of Nursing Home Monitoring

Nursing Care Facility **QUARTERLY NURSING STAFF REPORT**

1st Quarter Report – Calendar Year 2007

| Facility Name:Address: | | | | | | | | isi Quari | ст керог | t – Calci | idar 1 Ca | 1 2007 | | Di | eporting in the particular in | 2 | 1/21/07-1 /7/07 | /27/07 | | | | |
|---------------------------------|--------------------|----------------------|---------------------|-----------------------|-------------------------------|---------------------------------|----------------------|------------------------|----------------------|---------------------|-----------------------|-------------------------------|---------------------------------|-------------------------|---|----------------------|---------------------|-------------------------|-------------------------------|---------------------------------|--|--|
| DAY & DATE | | SUNDAY 1/21/07 | | | MONDAY 1/22/07 | | | TUESDAY 1/23/07 | | | WEDNESDAY 1/24/07 | | | THURSDAY 1/25/07 | | | DAY 6/07 | SATURDAY 1/27/07 | | | | |
| CENSUS | | | | | | | | | | | | | | | | | | | | | | |
| DIRECTOR OF NURSES (Hrs.) | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | TOTA | AL HO | URS WO | RKED PR | OVIDING | DIRECT | RESIDEN | T CARE | | | | | | | | | |
| | MORNING SHIFT | | | | | | | AFTERNOON SHIFT | | | | | | | NIGHT SHIFT | | | | | | | |
| | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDs IN HOUSE | AIDES/ ORDs POOL STAFF | | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDs IN HOUSE | AIDES/ ORDs POOL STAFF | | RNs IN HOUSE | RNs POOL STAFF | LPNs IN HOUSE | LPNs POOL STAFF | AIDES/ ORDs IN HOUSE | AIDES/ ORDs POOL STAFF | | |
| Sunday 1/21/07 | | | | | | | | | | | | | | | | | | | | | | |
| Monday 1/22/07 | | | | | | | | | | | | | | | | | | | | | | |
| Tuesday 1/23/07 | | | | | | | | | | | | | | | | | | | | | | |
| Wednesday 1/24/07 | | | | | | | | | | | | | | | | | | | | | | |
| Thursday 1/25/07 | | | | | | | | | | | | | | | | | | | | | | |
| Friday 1/26/07 | | | | | | | | | | | | | | | | | | | | | | |
| Saturday 1/27/07 | | | | | | | | | | | | | | | | | | | | | | |
| I hereby cer period indic | | I am the | administ | rator of | the above | facility a | and th | nat the in | formatio | n provide | ed herein | is a com | rect and | accurat | te record | of payro | ll records | s of the f | acility fo | r the | | |
| Administrator's Signature Typed | | | | | | yped A | Administrator's Name | | | | | | Da | Date | | | | | | | | |
| BHS-NHM-1 | 45 (Rev. | 11/4/05) | | | For | nursing ho | omes a | and count | y medical | care facil | ities, autl | hority is s | ection 217 | 720 a(2) | of Act 3 | 68 P.A. 19 | 978, as an | nended an | d Rule | | | |

Mandatory completion required:

325.20704. Failure to complete this form is actionable under Rule 325.20705. For hospital long-term care units, Rule 325.1027 applies.